

# SDI Online Tutorial: Filing a Disability Insurance (DI) Claim



State of California

# Employment Development Department

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## New Online Services

Services have been enhanced and automated. You can now file a claim for Disability Insurance and Paid Family Leave online, submit forms online, and view claim information online. To register, visit:



New! SDI Online

New! SDI Online En Español

New! Troubleshooting: Accessing SDI Online

### Previously registered with SDI Online?

If you have previously registered with SDI Online and want to log in to your account, visit:

[SDI Online Login](#)

[SDI Online Login En Español](#)

## Disability Insurance

- ▶ [How to File a DI Claim](#)
- ▶ [DI Eligibility](#)
- ▶ [DI Program Information](#)
- ▶ [DI Benefit Amounts](#)
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[More Disability Insurance Information](#)

## Paid Family Leave

- ▶ [How to File a PFL Claim](#)
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- ▶ [New! SDI Online](#)

[More Paid Family Leave Information](#)

To file a claim for Disability Insurance (DI) online, you must first have a State Disability Insurance (SDI) Online account.

To access your account:

- Visit [www.edd.ca.gov](http://www.edd.ca.gov).
- Select **Disability**.
- Select the **SDI Online Login** hyperlink.

Language: English ▾

Contact SDI

Online

By Location

By Phone

Telephone Numbers

Automated Info System

## SDI Online Login

\*Indicates Required Field

\*Username:

**Submit**

[Forgot username?](#)

[Register for a new online account](#)

**SECURITY REMINDER**  
Enter the username you provided during registration. We will ask you for your new password and display your personal image on the next screen.

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

On the **SDI Online Login** page enter your Username and select **Submit**.

Help | Login

Contact SDI

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Additional Authentication

\*Indicates Required Field

Security Questions

To continue, please correctly answer your security questions.

Question 1: Where did you celebrate your 21st birthday?

\*Answer to Question 1:

Next Cancel

If you do not recall your previous responses, please contact EDD at (800) 480-3287. The EDD staff is available from 8 a.m. to 5 p.m. (PT), Monday through Friday, except on [state holidays](#).

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In some instances, a claimant may be asked to respond to the security questions established when creating the account.

Type the answer to the security question and select **Next**.

Help | Login


Contact SDI  
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## Confirm Your Personal Image and Log In

**\*Indicates Required Field**

Verify your personal image and enter your password.

Personal Image:



Personal Image Caption: Test

Username:

\*Password:  (case sensitive)

Log In

[Forgot your personal image?](#)  
[Incorrect personal image showing?](#)  
[Forgot password?](#)

**SECURITY REMINDER**  
Recognizing your Personal Image and Personal Image Caption helps you know that you are at a valid EDD web site, and that it is safe to enter your password.

If you do not recognize your personal image, do not enter your password.

Back to Top | Conditions of Use | Privacy Policy | Equal Opportunity Notice

Confirm the Personal Image and enter your Password. Then select **Log In**.

**Note:** the Personal Image helps identify that the user has entered the correct Username on the previous screen.

Home  
Inbox  
File a New Claim  
Continue a Saved Draft  
Manage My Profile  
My Claim History  
SCDB Login  
Contact Us

## Personal Information

Full Name: John Doe

EDD Customer Account Number: 000-00-0000

Mailing Address: 123 Main St.  
Stockton, CA 95204-3512  
United States

Phone Number: 000-000-0000

Residence Address: 123 Main St.  
Stockton, CA 95204-3512  
United States

Cell Phone Number: 000-000-0000

E-mail Address:

## Message Center

Check the message center Inbox below to review messages and take required actions as needed.

[Inbox](#) [New: 0 , Total: 0 ]

**Current Disability Insurance Claim(s)**

No Results Found

### Pending Disability Insurance Claim Application(s)

No Results Found

### Submitted Paid Family Leave Claim Forms

Only forms you submitted online are listed below. Paid Family Leave claim status is currently not available online. For assistance with a Paid Family Leave claim you may call 1-877-238-4373.

No Results Found

Once you have successfully logged into your account, you will be directed to the **Home** page.

Select **File a New Claim** from the Main Menu.

## Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits.

### Apply for Disability Insurance Benefits

[Disability Insurance](#)

### Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

### Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

No Results Found

Delete

Select the  
**Disability  
Insurance** link.

## Disability Insurance Claim Filing Instructions

### Before You Start and After You File

Please have the following information available while completing this form:

- Most current employer(s) business name, telephone number, and mailing address as stated on your W2 form and/or paycheck stub.
- Last date you worked your regular or customary duties and hours.
- Date you began working at less than full duty or modified duty.
- Wages you received or expect to receive from your employer: sick leave, paid time off (PTO), vacation pay, annual leave, and wages earned after you stopped working.
- Workers' Compensation claim information, if applicable.
- The name, address, and telephone number, if any, of the Alcoholic Recovery Home or Drug-Free Facility where you are currently receiving in-patient treatment.
- You are responsible for obtaining a Physician/Practitioner Certification for your disability. Your claim will be returned if the Physician/Practitioner Certification is not received within 30 days. Please note that your employer will be notified that you have submitted a DI claim. However, your detailed claim information is confidential and will not be shared with your employer.

**Next** Cancel

This screen provides important information about the items you will need to file a DI claim.

Read this screen and select **Next** to proceed.



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Personal Initial Questions Employment Additional Certification  
Information Information Information Information

You are currently on Step 1 Personal Information

**Section 1 - Personal Information**

Social Security Number: XXX-XX-1234	EDD Customer Account Number: <input type="text"/>
Legal Name: John Doe	California Driver License or ID Number: <input type="text"/>
Date of Birth: 00-00-0000	Gender: <input type="text"/>
Preferred Language: <input type="text"/>	
Mailing Address: 123 Main St. Stockton, CA 95204-3512 United States	Residence Address: 123 Main St. Stockton, CA 95204-3512 United States
Home Phone Number: <input type="text"/>	Cell Phone Number: <input type="text"/>

**Section 2 - Other Names and Social Security Numbers Used**

Please enter any other names or other Social Security Numbers under which you have worked. If you have never worked under another name or Social Security Number please leave blank.

First Name: <input type="text"/>	Middle Initial: <input type="text"/>
Last Name: <input type="text"/>	Suffix: <input type="text"/>
Social Security Number: <input type="text"/>	
First Name: <input type="text"/>	Middle Initial: <input type="text"/>
Last Name: <input type="text"/>	Suffix: <input type="text"/>
Social Security Number: <input type="text"/>	

Information from your SDI Online account will automatically populate portions of the DI application.

Verify that information and complete any open fields, as appropriate.

Then select **Next**.

**Note:** select **Save as Draft** at any point in the process to complete the form at a later time.

Utilities

Set Application User  
Date Time  
Refresh User  
Add BOCs Claim Note

\*Indicates Required Field

Section 3 - Employment Information

\*Are you self employed?
☐ Yes
☒ No

\*Are you a State Government employee?
☐ Yes
☒ No

\*At any time during your disability, were you in the custody of law enforcement authorities because you were convicted of violating law or ordinance?
☐ Yes
☒ No

\*Before your disability began, what was the last day you worked?
 (MMDDYYYY)

\*When did your disability begin?
 07162012 (MMDDYYYY)

Date you want your Disability Insurance claim to begin if different than the date your disability began:
 (MMDDYYYY)

\*Since your disability began, have you worked or are you working any full or partial days?
☐ Yes
☒ No

\*Have you recovered?
☐ Yes
☒ No

\*Have you returned to work?
☐ Yes
☒ No

\*What is your regular or customary occupation?

\*Why did you stop working?
 Illness, Injury or Pregnancy

\*How would you describe or classify your job?

☒ Mostly sitting; occasionally standing and walking; occasionally lift, carry, push, pull or otherwise move objects that weigh 10 lbs. or less

☐ Walking/standing most of the time; occasionally lift, carry, push, pull or otherwise move objects that weigh up to 20 lbs.

☐ Constantly lift, carry, push, pull or otherwise move objects that weigh up to 10 lbs.; frequently up to 20 lbs.; occasionally up to 50 lbs.

☐ Constantly lift, carry, push, pull or otherwise move objects that weigh up to 20 lbs.; frequently up to 50 lbs.; occasionally up to 100 lbs.

☐ Constantly lift, carry, push, pull or otherwise move objects that weigh up to 20 lbs.; frequently over 50 lbs.; occasionally over 100 lbs.

\*Has or will your employer continue to pay you during your disability leave?
☐ Yes
☒ No

If "Yes," indicate type(s) of pay:
☐ Sick
☐ Vacation
☐ Paid Time Off
☐ Annual Leave
☐ Other Type of Pay

Other Type of Pay:

\*May we disclose benefit payment information to your employer(s)?
☒ Yes
☐ No

\*Have you filed or do you intend to file for Workers' Compensation benefits?
☐ Yes
☒ No

\*Was this disability caused by your job?
☐ Yes
☒ No

\*Are you a resident of an alcohol recovery home or drug-free facility?
☐ Yes
☒ No

Previous

Next

Save as Draft

Cancel

Complete the Employment Information section and select **Next**.

Mandatory fields are marked with a red asterisk.

## Employment Summary



You are currently on Step 3 Employment Information

### Section 4A - List of Employers

Please click the "Add" button to add information about your last or current employer. You must add at least one employer.

No Results Found

Previous

Next

Add

Save as Draft

Cancel

Select the **Add** button to add information about your last or current employer.

**Employer Search**

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Personal Initial Questions Employment Additional Certification  
Information Information Information

You are currently on Step 3 Employment Information

\*Indicates Required Field

**Section 4B - Search Criteria**

Please search for your current or most recent employer. After clicking the "Search" button, if your employer is not found, click the "Not Found" button to enter your employer information.

\*Employer Name: Begins With

**Search** **Reset**

Enter the Employer Name then select **Search**.

Search options include "Begins With," "Exact," and "Sounds Like."

## Employment Summary



You are currently on Step 3 Employment Information

### Section 4A - List of Employers

Please click the "Add" button to add information about your last or current employer. You must add at least one employer.

Employer Name	Employer Address	Last Day Worked	Action
Employment Development Department	800 Capitol Mall Sacramento, CA 95814-4807 United States	12-31-2011	<a href="#">Delete</a>

Previous

Next

Add

Save as Draft

Cancel

Search results will populate. Verify the employer and select **Next**.

Select the Add button to list more than one employer.

You are currently on Step 3 Employment Information

**\*Indicates Required Field**

**Section 4C - Employer Contact Information**

Enter your current or most recent employer's contact information as found on your W2 and/or paycheck stub. If you are a State government employee, enter the agency name (for example, Caltrans). If you are self-employed, enter "Self."

Last or Current Employer Name: Company Name

☒ US ☐ International

Address Line 1:

Address Line 2:

City:

State:

ZIP Code:

Employer Phone Number:  Ext:  ☐ Check here if the phone number is international  
(No dashes or spaces)

**Employment Information**

\*Before your disability began, what was the last day you worked for this employer?  (MMDDYYYY)

\*Do you currently have another employer that you have not yet reported? ☐ Yes ☒ No

[Previous](#) [Next](#) [Save as Draft](#) [Cancel](#)

This screen appears if you selected the Add button on the previous screen

Complete the Employer Contact Information and Employment Information sections, then select **Next**.

## Address Validation

The address you have provided has been updated to meet USPS standards. Please verify the address is correct.

### Entered Address

123 Main St.  
Anytown

### Updated Address

123 Main St.  
Anytown, CA 95814-0012

Would you like to proceed with the standardized address? Select 'Yes' to proceed or 'No' to return to correct the address.

Yes

No

The SDI Online system may standardize the address. Confirm the Updated Address section is correct by selecting **Yes**.

Select **No** to go back to the previous screen and re-enter the address.

## Employment Summary



You are currently on Step 3 Employment Information

### Section 4A - List of Employers

Please click the "Add" button to add information about your last or current employer. You must add at least one employer.

Employer Name	Employer Address	Last Day Worked	Action
ABC Employer	123 Main St Anytown, CA 95814 United States	05-14-2012	<a href="#">Delete</a>

[Previous](#)

[Next](#)

[Add](#)

[Save as Draft](#)

[Cancel](#)

Confirm the Employment Information and select **Next**.



**Declaration**

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 Personal Information Initial Questions Employment Information Additional Information Certification

**You are currently on Step 5 Certification**

**\*Indicates Required Field**

**Section 8 Declaration**

☒ By my signature on this claim statement, I claim benefits and certify that for the period covered by this claim I was unemployed and disabled. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law and that such violation is punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. By my signature on this claim statement, I authorize the California Department of Industrial Relations and my employer to furnish and disclose to State Disability Insurance all facts concerning my disability, wages or earnings, and benefit payments that are within their knowledge. By my signature on this claim statement, I authorize release and use of information as stated in the "Information Collection and Access" portion of this form. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature of the effective date of the claim, whichever is later.

**Health Insurance Portability and Accountability Act (HIPAA)**

☒ I authorize the below named Physician/Practitioner to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers, and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits. I understand that the EDD is not a health plan or health care provider, so the information released to the EDD may no longer be protected by federal privacy regulations (42 CFR Section 165.508©(2)(iii)). The EDD may disclose information as authorized by the California Unemployment Insurance Code. I agree that photocopies of this authorization shall be as valid as the original. I understand I have the right to revoke this authorization by sending written notification stopping this authorization to the EDD, DI Branch MIC 29, PO Box 826880, Sacramento. This authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further Disability Insurance benefits. I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by the EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent the EDD's recovery of monies to which it is legally entitled. I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of Disability Insurance benefits. I understand I have the right to receive a copy of this authorization.

Authorized Physician/Practitioner Name:

To print or view your application in a new window, select [Claim for Disability Insurance \(DI\) Benefits \(DE 2501\)](#). To save and file your claim, select [Submit](#).

[Submit](#) [Save as Draft](#) [Cancel](#)

Select the first box to authorize an electronic signature.

Select the second box and enter the physician/practitioner name in the field.

Both boxes must be selected to complete your claim.

Select **Submit** to finalize the process.

Select **Claim for Disability Insurance (DI) Benefits (DE 2501)** to view or print your application.

## Confirmation

### Confirmation

You are responsible for providing this receipt number to your physician or practitioner so that they may submit a Physician/Practitioner Certificate for your claim. Your claim form is not complete without the Physician/Practitioner Certificate. Your physician or practitioner will use this receipt number to file the Physician/Practitioner certificate online or by mail.

Your completed claim form must be received no earlier than 9 days, but no later than 49 days, after the first day you became disabled. If your completed claim form is late, you may lose benefits. Most claims are processed within 14 days of receipt of a properly completed claim form, which includes your portion of the DE 2501 and the Physician/Practitioner certificate.

Certification can be made by a licensed medical or osteopathic physician and surgeon, chiropractor, dentist, podiatrist, optometrist, designated psychologist, or an authorized medical officer of a United States Government facility. Certification can be made by a nurse practitioner for disabilities other than normal pregnancy or childbirth after performance of a physical examination and collaboration with a physician and/or surgeon. Certification may also be made by a certified nurse-midwife, nurse practitioner, or licensed midwife for disabilities related to normal pregnancy and childbirth. Certification by a religious practitioner is acceptable only if the practitioner has been accredited by the Employment Development Department.

If you are receiving temporary Workers' Compensation benefits and are filing for reduced SDI benefits for the same disability period, the Physician/Practitioner certificate may not be required. Please call the Disability Insurance Customer Service Center at (800) 480-3287 for further instructions.

Print this page for your records and record the Form Receipt Number below. For future reference, you can also view your form on your Home page by selecting the same receipt number. This page is only a confirmation that your application has been received by the DIA system and is not meant to imply that you have been found eligible to receive SDI benefits.

Form Receipt Number **R10000000060977**

### Customer Satisfaction Survey

Your opinion is important to us. Select the link below to complete a survey about your online experience.

[Link to Survey](#)

The **Confirmation** screen will provide a **Form Receipt Number**, which needs to be provided to the physician or practitioner.

**Note:** your physician can complete the medical portion of the hard copy claim form, Claim for Disability Insurance (DI) Benefits (DE 2501), if they do not want to submit the form online.

Visit [www.edd.ca.gov](http://www.edd.ca.gov) for more information about State Disability Insurance.

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-800-480-3287 (voice), or TTY 1-800-563-2441.